

MFP

Kentucky Transitions :
Making Your Choices Our First Priority

Kentucky Cabinet for Health and Family Services
Medicaid & Department of Aging and Independent Living

What is Kentucky Transitions?

- Kentucky Transitions is a program designed to assist those in Medicaid institutions (Nursing Facilities and ICF/MRs) out into community settings, if they desire.
- The program will serve individuals who are elderly, physically disabled, have mental retardation or a developmental disability or those with an acquired brain injury.

What is Kentucky Transitions?

- A state program that will use existing community based waiver services to help transition individuals from the nursing facility and Intermediate Care Facility into an integrated community environment. The existing waivers will need additional and expanded services and providers to meet the needs of these individuals.

Money Follows the Person:

Where an individual's services will follow them into a community environment after leaving a facility.

- The **choice to live** in the community with support services
- The individual's **choice** of care settings in which to reside;
- Based upon the **availability of providers**; and
- The **availability of state programs** for which the individual qualifies.

How is Kentucky Transitions Funded?

- Kentucky has been awarded an enhanced match of up to \$49 million in funds from the Center for Medicare and Medicaid Services (CMS).
- To receive the grant, Kentucky submitted a proposal to CMS. CMS requires the state to submit an Operational Protocol that outlines the details of the MFP demonstration. Upon approval of that document, Kentucky will administer the program in the state.

Planning and Developing

- **Organizational Structure:**

- Policy Management Team includes the two Commissioners of Dept. for Medicaid Services and the Dept. for Aging and Independent Living, and the MFP Project Director.
- Steering Committee is made up of advocates and stakeholders who participate in meetings specific to the implementation of the Kentucky Transition program.
- Kentucky Transitions Workgroups convene to assess specific developmental issues of the program.
- Project staff participates in training and technical assistance teleconferences with CMS.

Planning and Development

- **Workgroups—**
 - Eligibility and Policy
 - Assessment and Services
 - Transition and Monitoring
 - Outreach/Marketing and Education
 - Provider Network
 - Transportation
 - Financial, Information Technology and Reporting

HOW WILL IT WORK?



MFP Staff is contacted by individual or referral source.



Transition team begins Educating Individual and Family/Guardians.



With direction from individual, transition process begins.

Transition Process

Start

Education and Information provided on **Kentucky Transitions**

Participant/ Guardian chooses to transition and provides informed consent

Participant screened for eligibility for **Kentucky Transitions**

NEXT

Housing options are presented and participant makes housing choice

Transition Plan is developed and approved and community resources are identified

Participant is assessed for medical, social and housing needs.

Housing is finalized, Transition needs are addressed and providers are chosen

Transition readiness is assessed by the participant and the team

Transition team prepares participant for move to the community

Finish

Participant is monitored and evaluated

Participant Relocates to home in the community

Determining Eligibility

- Medicaid eligibility and medical care needs.
 - Eligible participants will have been in an LTC facilities for at least six months with the last month being Medicaid Eligible.
 - Both the individual and guardian have to agree that moving into the community is the intent (must sign Informed Consent Document).
 - After initial eligibility has been met, the participant will then move to the next phase of the transition process where they will meet with the Transition team to discuss further criteria and options.

Transition Planning

- Once individual has been screened and deemed eligible to proceed they will begin the transition process. The transition coordinators will then assess the individual and the team will participate in developing the care plan. Each individual and/or guardian will be at the center of all planning. They will be making the decisions.

Housing

- Individuals have the option of living on their own, with family members, or in a group home with no more than four other non-related household members.
- For those who do not have housing already established in the community, a housing coordinator on the transition team will assist the individual in finding appropriate housing and receiving the proper home modifications for their environment.

Medical Care Needs

- Before the transition, each individual's care plan will include an appointment with the new physician in the community. The team will arrange for first pick-ups from the pharmacy.
- The team will also include all therapy and necessary medical services through community providers in the care plan.

Transportation

- The transition team will assist the individual in finding transportation for a number of services including going to medical appointments, the pharmacy, the grocery, and attending social events such as church or adult day care.

Waiver Services

- Each individual's services will vary according to the waiver population they represent. The care plans will include the appropriate services for which Kentucky Transitions program will be able to provide. These services may range from personal care and homemaking to respite and behavioral supports. All services will be described in benefits package.

All Services

- All services will be accessed before the individual moves into the community. The goal is for the individual to have all plans developed so that after they transition into the community they will remain living at home.
- Emergency Back-up Plans are a KEY PART of the individuals care plans.

Who will develop the individuals care plan?

- The Individual
- Guardian and/or Family Member
- Transition team: Social Worker, Registered Nurse, Housing Coordinator
- Service Providers (medical and social)
- Community Partners (medical and social)

What is the purpose of the Assessment Form?

- The assessment form provides the Transition team with written communication and direction for the individuals plan of care.
- Identifies the specific needs and desires of the individual.
- Encompasses all areas of care for the individual.
- Ensures that the plan of care will include all supports to sustain the individual in the community.

What's in an ASSESSMENT?

- The transition team conducts a complete medical, psycho-social assessment by reviewing the individuals' charts, interviewing staff, speaking with transition participant, and conducting other screening activities. The history of any care of the individual is reviewed and options for post-discharge care are discussed with them. From this review, transition goals are established and community agencies that can provide services are identified.

Who should be referred to the Transition Program?

- Any resident who expresses a desire to live in the community should be referred to the Kentucky Transition Program.

Are there any financial obligations to the transition consumer?

- The grant allows each participant a transition allowance not exceeding what it cost for them to remain in a facility. After the individuals grant year is over, the financial obligation of the participant will be allocated through a Medicaid waiver program. Anything not covered under a waiver is considered to be the patient liability.

How does the individual participate?

- The interested individual or guardian can contact the State Transition Team, Nursing Home Ombudsman, or the Department for Aging and Independent Living.

Why Kentucky Transitions?



Individual Choice



Care Options



Living Supports



Sustainability



Freedom



Community Living



Social Life



Turning Lives Around, One Choice at a Time